

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | | | |
|---|--|---|--|---|--|
| 1 PLACE OF DEATH County <u>Kent</u> | | 5030 | | (43) STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Rock Hall</u> | | (No. _____) | | Registration Dist. No. <u>203</u> | |
| 2 FULL NAME <u>Alice Ann Ayers</u> | | | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word) | | | |
| 6 DATE OF BIRTH <u>Feb 28</u> , 18 <u>56</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>5-8</u> yrs. <u>2</u> mos. <u>25</u> ds. | | If LESS than 1 day, hrs. OR min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House Keeper</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ | | | | | |
| 9 BIRTHPLACE (State or country) <u>Kent Co Ma</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>William H Coleman</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Kent Co Ma</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Elizabeth A. Coleman</u> | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Kent Co Ma</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mary C Casey</u> (Address) <u>Rock Hall Ma</u> | | | | | |
| 15 Filed <u>4/26</u> , 191 <u>4</u> <u>T. B. Darding.</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>May 23rd</u> , 191 <u>4</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, that I attended deceased from <u>Oct 15th</u> , 191 <u>3</u> , to <u>May 23rd</u> , 191 <u>4</u> , that I last saw him alive on <u>date above</u> , 191 <u>4</u> and that death occurred on the date stated above, at <u>11:45</u> p. m. The CAUSE OF DEATH* was as follows: <u>Carcinoma of Breast or mammary gland</u> (Duration) <u>2</u> yrs. mos. ds. Contributory (Secondary) _____ (Duration) yrs. mos. ds. (Signed) <u>Amos H Beall</u> , M. D. <u>May 25th</u> , 191 <u>4</u> . (Address) <u>Rock Hall Md</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>2</u> yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____ | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u> Wesley Chapel Cemetery</u> | | | | DATE OF BURIAL <u>April 26</u> , 191 <u>4</u> | |
| 20 UNDERTAKER <u>Thos H Casey & Co</u> | | | | ADDRESS <u>Rock Hall</u> | |

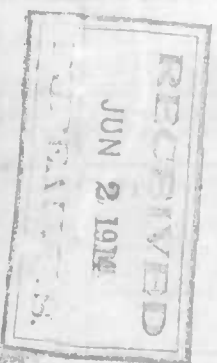
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5031

(151)

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Kent

Registration Dist. No.

204

Village or City

near Fairlee

(No.

Worton

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Maud Lavinia Berry

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

col

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

May 10, 1914
(Month) (Day) (Year)

7 AGE

yrs. mos. 4 ds.

It LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Kent Co Md.

PARENTS

10 NAME OF FATHER

Lavinia Berry

11 BIRTHPLACE OF FATHER
(State or country)

Kent Co Md.

12 MAIDEN NAME OF MOTHER

Dora Briscoe

13 BIRTHPLACE OF MOTHER
(State or country)

Kent Co Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lavinia Berry

(Address)

Worton 1 Md.

15

Filed

May 15, 1914 F. N. Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 14, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

no medical, 191

that I last saw h. alive on attention, 191

and that death occurred on the date stated above, at 11 P.m.

The CAUSE OF DEATH* was as follows:

Dysentery, 5th month.
(Duration) yrs. mos. ds.Contributory
(Secondary)(Signed) F. N. Smith, M. D.
May 15, 1914 (Address) F. N. Smith

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

near Fairlee 1 Co Md.

May 15, 1914

20 UNDERTAKER

ADDRESS

Lehas L. Dodd, Chestertown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

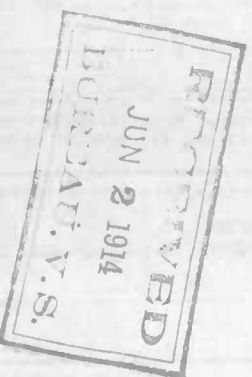
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cooling*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | |
|---|---|--|--|---|--|
| 1 PLACE OF DEATH <i>Kent</i> | | 5032 | | (92) STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County <i>Kent</i> | | Registration Dist. No. <i>204</i> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| Village or City <i>Fairlee</i> | | (No.) | | St.; Ward) | |
| 2 FULL NAME <i>Julius Blake</i> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <i>Female</i> | 4 COLOR OR RACE <i>col</i> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Single</i> (Write the word) | | | |
| 6 DATE OF BIRTH <i>May 4, 1899</i> (Month) (Day) (Year) | | | | | |
| 7 AGE <i>15 yrs. 11 mos. 26 ds.</i> If LESS than 1 day.....hrs. OR.....min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <i>none</i> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <i>Kent Co. Md</i> | | | | | |
| PARENTS | 10 NAME OF FATHER <i>Richard Blake</i> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <i>Kent Co. Md</i> | | | | |
| | 12 MAIDEN NAME OF MOTHER <i>Rebecca Cole</i> | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <i>Kent Co. Md</i> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Richard Blake</i> (Address) <i>Worton 1 Md.</i> | | | | | |
| 15 Filed <i>May 1, 1914</i> <i>J. H. Smith</i> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <i>May 1, 1914</i> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <i>April 15, 1914</i> , to <i>May 1, 1914</i> , that I last saw her alive on <i>May 1, 1914</i> , and that death occurred on the date stated above, at <i>1 A-m</i> , The CAUSE OF DEATH* was as follows: | | | | | |
| <i>Pneumonia</i> <i>Lobar. Pneumonia</i> (Duration) yrs. mos. <i>14</i> ds. | | | | | |
| Contributory (Secondary) <i>Feritoidia</i> (Duration) yrs. mos. <i>6</i> ds. | | | | | |
| (Signed) <i>Frank W. Smith</i> , M. D. <i>May 1, 1914</i> . (Address) <i>Chestertown</i> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <i>Fairlee K. Co. Md</i> DATE OF BURIAL <i>May 3, 1914</i> | | | | | |
| 20 UNDERTAKER <i>Chas. L. Dodde</i> ADDRESS <i>Chestertown</i> | | | | | |

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

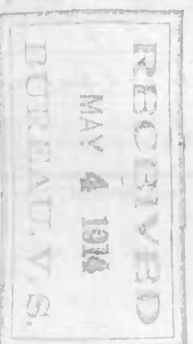
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Kent 5033STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 212Village or City Chestertown (No. Cross)

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Maggie Butler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Gold 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Don't know 1901
(Month) (Day) (Year)

7 AGE 13 Don't know If LESS than 1 day, hrs. OR min. ?
yrs. mos. ds.

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Kent Co. Md.

10 NAME OF FATHER Michael Butler

11 BIRTHPLACE OF FATHER (State or country) Kent Co. Md.

12 MAIDEN NAME OF MOTHER Annie Henry

13 BIRTHPLACE OF MOTHER (State or country) Kent Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Michael Butler(Address) Michael Butler

15 Filed May 8, 1914 W. H. Hicks
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 17, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1914 to May 19, 1914, that I last saw her alive on May 17, 1914

and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

This was a strumous child. It was vaccinated in March 1914, a general vaccination, and with a specific vaccination second.
(Duration) yrs. 2 mos. ds.

Contributory Secondary

(Signed) W. H. Hicks, M. D.
May 18, 1914 (Address) Chestertown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOMES, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL near Chestertown Md. DATE OF BURIAL May 18, 1914

20 UNDERTAKER Chas. L. Dodd ADDRESS Chestertown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

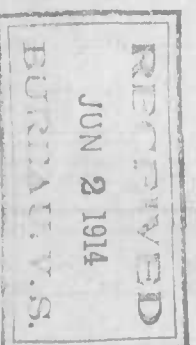
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housewife*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tracema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, STRUCK, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

1 PLACE OF DEATH 5034

Kent Co

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 200

Village or City Lansapas (No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary Carpenter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH March, 1865
(Month) (Day) (Year)

7 AGE 39 yrs. 3 mos. 0 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Cambridge Md

10 NAME OF FATHER Joseph Cephus

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Elyse Nicholas

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos. Cephus(Address) Lansapas Md

15 Filed 3^d 28th 1914 4 Harry Griffith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH 5 26, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1914, to May 23, 1914.

that I last saw him alive on May 17, 1914

and that death occurred on the date stated above, at 1. a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis(Duration) 1 yrs. 6 mos. 0 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. E. Black, M. D.5-26-14, 1914 (Address) Middleton Del

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cecilton CemeteryMarch 27, 1914

20 UNDERTAKER

ADDRESS

Andrew J. GreenMiddleton Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

by U. S. Census and American Public Health Association.¹

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question

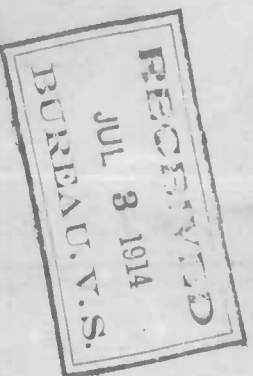
of each and every person, irrespective of age, occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

Spinner, (b) Cotton mill; (a) Salesman, (b) Clerk; (a) Foreman, (b) Automobile factory. The first worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—(volunteering, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.. *Carcin-*

oma. Sarcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 da.; Bronchopneumonia* (secondary), *10 da.* Never report mere symptoms or terminal conditions, such as "Anthrax," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestive"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be sketched under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5035

County

Kent

Village or City

Chester town (No. 10000)

Registration Dist. No.

203

St.

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Jm T Henry

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word)

married

6 DATE OF BIRTH

Oct 4th, 1838
(Month) (Day) (Year)

7 AGE

75 yrs. 7 mos. 20 ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

N. Jersey

PARENTS

10 NAME OF FATHER

Mo Henry

11 BIRTHPLACE OF FATHER
(State or country)

N. Jersey

12 MAIDEN NAME OF MOTHER

Ruth Teller

13 BIRTHPLACE OF MOTHER
(State or country)

N. Jersey

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Annie R. Henry
Chester town Md
(Address)

15

Filed

May 26, 1914 W. T. Hicks
Local REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 23, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

1914, to May 23, 1914

that I last saw him alive on May 22, 1914

and that death occurred on the date stated above, at 12-45 m.

The CAUSE OF DEATH* was as follows:

Apooplexy
2nd stroke

(Duration) 30 4 yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

H. A. Singers

M. D.

May 14, 1914 (Address) Chester town

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chester town

May 26, 1914

20 UNDERTAKER

ADDRESS

Chas. L. Dodd Chester town

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

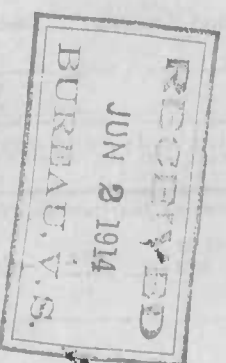
[Approved by U. S. Census and American Public Health Association.]

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Statement of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic interstitial nephritis*; *radicular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, STUPIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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5036

1 PLACE OF DEATH

County KentSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 205Village or City Brownstown Snake Neck Kent Co. (No. _____)

St.; Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Maria Houston

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Cald 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Don't know 1849
(Month) (Day) (Year)

7 AGE 65 Don't know It LESS then
1 day, ____ hrs. ____ yrs. ____ mos. ____ ds. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Kent County Md.

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (State or country) Don't know Kent Co.

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (State or country) Kent Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maria Houston(Address) W. C. Townsend

15 Filed May 30 1914 W. C. Townsend
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 8 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from occasionally about June 1913 to May 2 1914
that I last saw her alive on June 1913

and that death occurred on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast
according to history 30
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) H. Benge Simmons, M. D.
59 1914 (Address) Chestertown Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, It not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Snake Neck Kent Co. Md. DATE OF BURIAL May 10 1914

20 UNDERTAKER

Charles L. Dodd ADDRESS Chestertown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 5037

County KentVillage or City Chestertown (No. Prospect St.; Ward)

79 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 202

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Josiah M. Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Cold 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH don't know
(Month) (Day) (Year)

7 AGE 70 yrs. don't know It LESS than 1 day, hrs. OR mos. ds. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Harm hand
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Kentles Md.

10 NAME OF FATHER James Jones

11 BIRTHPLACE OF FATHER (State or country) Kentles Md.

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (State or country) Kentles Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Julia Jones(Address) Chestertown Md.15 Filed May 26, 1914 W. H. Hicks

Zora REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 23rd, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1914 to on visit, 1914

that I last saw him alive on May 22, 1914

and that death occurred on the date stated above, at 11-12 m.

The CAUSE OF DEATH* was as follows:

Congestion of the Lungs
(Passive)

(Duration) yrs. mos. ds. 4

due to Chronic Endo-
Contributory
Secondary
carditis (Valvular Dis.)

(Duration) yrs. mos. ds. 5

(Signed) Harry L. Dodd, M. D.

May 26, 1914 (Address) Chestertown, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Near Chestertown Md May 26, 1914

20 UNDERTAKER ADDRESS

W. H. L. Dodd Chestertown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

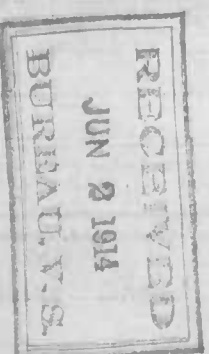
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the MISASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic interstitial nephritis; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fenial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicac-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIO-LENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—acci-dent; Revolver wound of head—homicide; Poisoned by carboic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomencla-ture of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | | | | | |
|---|--|--|--|-----------------------------|--|---|--|
| 1 PLACE OF DEATH | | 5038 | | (37) | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County | | Kent | | Registration Dist. No. | | 202 | |
| Village or City | | Chestertown | | (No. Prospect | | St.; Ward) | |
| 2 FULL NAME | | Louise Kennedy | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | | |
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) | | | | | |
| Female | Col | Single | | | | | |
| 6 DATE OF BIRTH | | | | | | | |
| Sept 19 th , 1912 | | (Month) (Day) (Year) | | | | | |
| 7 AGE | | If LESS than 1 day, hrs. 29 th ds. OR min. ? | | | | | |
| 1 yrs. 7 mos. 29 th ds. | | | | | | | |
| 8 OCCUPATION | | None | | | | | |
| (a) Trade, profession, or particular kind of work. | | | | | | | |
| (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | | | |
| 9 BIRTHPLACE (State or country) | | Kent les Md. | | | | | |
| PARENTS | 10 NAME OF FATHER | Chas Kennedy | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) | Kent les Md | | | | | |
| | 12 MAIDEN NAME OF MOTHER | Sadie Granger | | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) | Kent les Md. | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | | | | | |
| (Informant) | | Chas Kennedy | | | | | |
| (Address) | | Chestertown Md | | | | | |
| 15 Filed | | May 19, 1914 | | | | | |
| 16 | | W. S. Hicks | | | | | |
| | | Local REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | | |
| 18 DATE OF DEATH | | May 18 th , 1914 | | | | | |
| | | (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from | | | | | | | |
| Nov 29 | | 1913 to May 15, 1914 | | | | | |
| that I last saw h. alive on | | May 15, 1914 | | | | | |
| and that death occurred on the date stated above, at | | 2-10 th m. | | | | | |
| The CAUSE OF DEATH* was as follows: | | | | | | | |
| Syphilis | | | | | | | |
| Contributory | | (Duration) 1 yrs. 8 mos. — ds. | | | | | |
| Secondary | | | | | | | |
| (Signed) | | H. Benge Simmons, M. D. | | | | | |
| May 19, 1914 | | (Address) Chestertown | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | | | | | | | |
| At place of death | | yrs. mos. ds. | | In the State | | yrs. mos. ds. | |
| Where was disease contracted, If not at place of death? | | | | | | | |
| Former or usual residence | | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL | | | | DATE OF BURIAL | | | |
| near Chestertown Md. | | | | May 20 th , 1914 | | | |
| 20 UNDERTAKER | | | | ADDRESS | | | |
| Chas L. Sodd. | | | | Chestertown | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

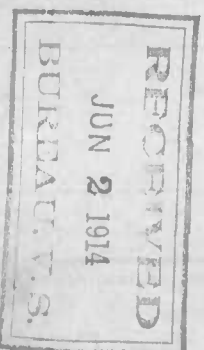
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probable* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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PLACE OF DEATH 5039

County KentVillage or City Galena (No. _____, St.; _____ Ward)

(113) STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 200

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME Charles F. Lehmann

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH dec 22, 1853
(Month) (Day) (Year)

7 AGE 60 yrs. 4 mos. 26 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) House & Carriage work

9 BIRTHPLACE (State or country) Prussia.

PARENTS
10 NAME OF FATHER Not known
11 BIRTHPLACE OF FATHER (State or country) Prussia.
12 MAIDEN NAME OF MOTHER Louise (Trampier name) not known
13 BIRTHPLACE OF MOTHER (State or country) Prussia.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daisy Lehmann(Address) Galena, Md

15 MAY 21 1914
FILED Julius J. Jones
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 18, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 1914 to May 18th 1914.

that I last saw him alive on May 18th 1914

and that death occurred on the date stated above, at 8.30 P.m.

The CAUSE OF DEATH* was as follows:

Toxaemia, Cirrhosis of Liver & kidneys; conditions have existed several years, has been under my care about 6 months
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) Edward Herbert, M. D.

May 19th 1914 (Address) Galena, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Galena, Md. DATE OF BURIAL May 21, 1914

20 UNDERTAKER Wm. T. Hicks ADDRESS Chestertown Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

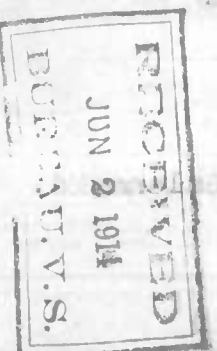
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name or sign; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestive," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5040

County

Kent

Village or City

Kennedyville

2 FULL NAME

Mary A. Meredith

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

201

St.; Ward)

[If death occurred in a hospital or institution, give his NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female
4 COLOR OR RACE white
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Jan 4, 1840
(Month) (Day) (Year)

7 AGE 74 yrs. 4 mos. 3 ds. OR 1 LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Charles W. Jester

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Meredith

(Address)

Kennedyville

15

Filed

May 9th, 1914 William Pass
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 7, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1914 to May 7, 1914, that I last saw her alive on May 7, 1914, and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) yrs. 4 mos. ds.
Contributory (Secondary) La Grippe

(Duration) yrs. mos. ds.
(Signed) Jas. W. Urie, M. D.
May 9, 1914 (Address) Kennedyville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Kennedyville DATE OF BURIAL May 10, 1914

20 UNDERTAKER W. H. Gruen ADDRESS Still Pond.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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oma. *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anaemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetania," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| 1 PLACE OF DEATH | | 5041 | | 74 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
|---|---|---|--|--|--|---|--|
| County <u>Kent</u> | | Village or City <u>Chesterstown, Md</u> | | Registration Dist. No. <u>202</u> | | [It death occurred in a hospital or Institution, give its NAME Instead of street and number.] | |
| 2 FULL NAME <u>John Minch</u> | | | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word) | | | | | |
| 6 DATE OF BIRTH <u>Aug. 17, 1830</u> (Month) (Day) (Year) | | | | | | | |
| 7 AGE <u>83</u> yrs. <u>9</u> mos. <u>1</u> ds. | | If LESS than 1 day, hrs. OR min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) | | <u>Farmer</u> | | | | | |
| 9 BIRTHPLACE (State or country) | | <u>Germany</u> | | | | | |
| PARENTS | 10 NAME OF FATHER | <u>Unknown</u> | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) | <u>Unknown</u> | | | | | |
| | 12 MAIDEN NAME OF MOTHER | <u>Unknown</u> | | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) | <u>Unknown</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. J. J. Schaub</u> (Address) <u>Chesterstown</u> | | | | | | | |
| 15 Filed <u>May 18, 1914</u> | | 16 REGISTRAR <u>W. A. Hicks</u> <u>Local</u> | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | | |
| 16 DATE OF DEATH <u>May 14, 1914</u> (Month) (Day) (Year) | | 17 I HEREBY CERTIFY, That I attended deceased from <u>no medical attention</u> that I last saw him alive on _____, 191____ and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Endocarditis. Sudden death.</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory <u>Pneumonia 1912.</u> (Duration) _____ yrs. <u>3</u> mos. _____ ds. (Signed) <u>Frank W. Smith</u> , M. D. <u>May 17, 1914</u> (Address) <u>Chesterstown, Md.</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____ | | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Church Hill</u> | | | | 20 DATE OF BURIAL <u>May 19, 1914</u> | | | |
| 21 UNDERTAKER <u>J. E. Brinquan</u> | | | | ADDRESS <u>Chesterstown Md</u> | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

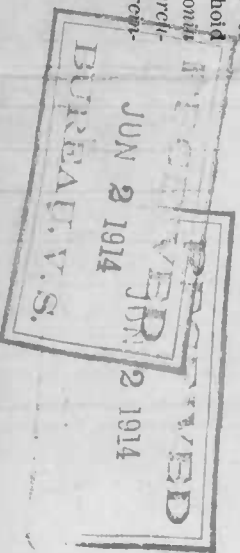
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 5042
County Neum.

Village or City Chestertown No. _____ St.; _____ Ward)

2 FULL NAME Cecil Almon Robinson

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 202

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Dec. 31, 1897
(Month) (Day) (Year)

7 AGE 17 yrs. 4 mos. 29 ds. It LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Telegraph Messenger
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Chester Co. Pa.

10 NAME OF FATHER David Robinson

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Annie E. Taylor

13 BIRTHPLACE OF MOTHER (State or country) Chestertown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Robinson

(Address) Chestertown, Md.

15 Filed May 30, 1914 W. S. Flicks
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 28, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from No Medical Attention

that I last saw him alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Accidental Drowning from Boat
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Accident
Secondary _____

(Signed) Franklin Smith, M. D.
May 29, 1914 (Address) Chestertown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Chestertown Md DATE OF BURIAL May 31, 1914

20 UNDERTAKER Chas L. Dodd ADDRESS Chestertown Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

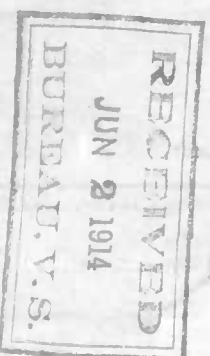
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculous* of *lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | | |
|---|---|---|-----------------|---------------------------------------|---|---|
| 1 PLACE OF DEATH <i>Kent</i> | | 5043 | 28 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County | | | | | Registration Dist. No. <i>203</i> | |
| Village or City <i>near Rock Hall</i> | | | (No. <i>7</i>) | St.; Ward) | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |
| 2 FULL NAME <i>Hattie Summes</i> | | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | |
| 3 SEX <i>Female</i> | 4 COLOR OR RACE <i>Black</i> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Married</i> (Write the word) | | | | |
| 6 DATE OF BIRTH <i>No Record</i> , 1870 (Month) (Day) (Year) | | | | | | |
| 7 AGE <i>44</i> yrs. <i>No Record</i> mos. ds. | | If LESS than 1 day.....hrs. OR.....min. ? | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <i>Servant</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>Cook & Gen'l work</i> | | | | | | |
| 9 BIRTHPLACE (State or country) <i>Kent - County, Md</i> | | | | | | |
| PARENTS | 10 NAME OF FATHER <i>William H. White</i> | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <i>Kent - Co. Md</i> | | | | | |
| | 12 MAIDEN NAME OF MOTHER <i>Adelaide Brown</i> | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <i>Kent - Co. Md</i> | | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Martha Jones</i> (Address) <i>R.R. #2 Rock Hall</i> | | | | | | |
| 15 Filed <i>5/7</i> , 1914 <i>T. B. Durdan</i> REGISTRAR | | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | |
| 16 DATE OF DEATH <i>May 5</i> , 1914 (Month) (Day) (Year) | | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <i>No Medical</i> , 1914 that I last saw him alive on <i>attention</i> , 1914 and that death occurred on the date stated above, at <i>5 A</i> m. THE CAUSE OF DEATH* was as follows: <i>Pulmonary Tuberculosis</i> (Duration) yrs. <i>5</i> mos. ds. Contributory (Secondary) <i>Neglect</i> (Duration) yrs. mos. ds. (Signed) <i>Frank W. Smith, Coroner, M.D.</i> <i>May 6</i> , 1914 (Address) <i>Chesapeake, Md</i> | | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted? If not at place of death? Former or usual residence. | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <i>Lower bottom cemetery</i> | | | | DATE OF BURIAL <i>May 7</i> , 1914 | | |
| 20 UNDERTAKER <i>Thos H Casey & Co</i> | | | | ADDRESS <i>Rock Hall</i> | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

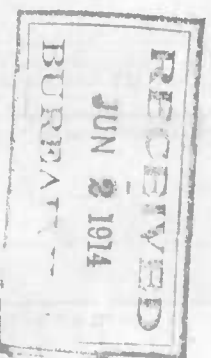
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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | | | |
|---|--|--|--|-----------------------------------|--|---|--|
| 1 PLACE OF DEATH County <u>Kent</u> | | 5044 | | (120) | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>New Laurel</u> (No. <u>Worton 1</u>) | | St. <u></u> Ward <u></u> | | Registration Dist. No. <u>304</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| 2 FULL NAME <u>Fredrick Wallace</u> | | | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>col</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u> | | | | | |
| 6 DATE OF BIRTH <u>unknown</u> , 1850 (Month) (Day) (Year) | | | | | | | |
| 7 AGE <u>64</u> yrs. <u>unknown</u> mos. <u>unknown</u> ds. If LESS than 1 day, <u>unknown</u> hrs. OR <u>unknown</u> min. ? | | | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>farm laborer</u> | | | | | | | |
| 9 BIRTHPLACE (State or country) <u>Kent Co</u> | | | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Fredrick Wallace</u> | | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Kent Co. Md</u> | | | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Harrnett</u> | | | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Kent Co Md</u> | | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Sallie Wallace</u> (Address) <u>Worton 1 Md</u> | | | | | | | |
| 15 Filed <u>May 23, 1914</u> <u>F. W. Smith</u> REGISTRAR | | | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | | |
| 16 DATE OF DEATH <u>May 22</u> , 1914 (Month) (Day) (Year) | | | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>May 19</u> , 1914, to <u>May 22</u> , 1914, that I last saw him alive on <u>May 21</u> , 1914, and that death occurred on the date stated above, at <u>2:30</u> p. m. The CAUSE OF DEATH* was as follows: <u>Chronic Nephritis</u> (Duration) <u>2</u> yrs. <u>unknown</u> mos. <u>unknown</u> ds. Contributory <u>Uremia</u> Secondary (Duration) <u>5</u> yrs. <u>unknown</u> mos. <u>unknown</u> ds. (Signed) <u>Frank C. Smith</u> , M. D. <u>May 22, 1914</u> (Address) <u>Chestertown</u> | | | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>unknown</u> yrs. <u>unknown</u> mos. <u>unknown</u> ds. In the State <u>unknown</u> yrs. <u>unknown</u> mos. <u>unknown</u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u>unknown</u> | | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Chestertown K. Co Md</u> DATE OF BURIAL <u>May 24, 1914</u> | | | | | | | |
| 20 UNDERTAKER <u>Worton 1 Md</u> ADDRESS <u>Chas L. Dodd Chestertown</u> | | | | | | | |

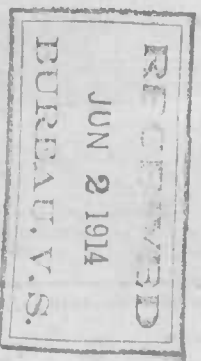
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[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Méasles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tracema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | | | | | | |
|--|--|---------------------------------|-----------------------------------|--|--|---|--|--|
| 1 PLACE OF DEATH County <u>Kent</u> | | | 5045 (66) | | | STATE OF MARYLAND CERTIFICATE OF DEATH | | |
| Village or City <u>Chestertown</u> (No. <u>Water</u> St.; <u>Ward</u>) | | | Registration Dist. No. <u>202</u> | | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | |
| 2 FULL NAME <u>Thomas Frank Gates</u> | | | | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | | | |
| 3 SEX <u>Male</u> | | 4 COLOR OR RACE <u>White</u> | | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widower</u> | | | | |
| 6 DATE OF BIRTH <u>December 21st</u> , 18 <u>43</u> (Month) (Day) (Year) | | | | | | | | |
| 7 AGE <u>70</u> yrs. <u>4</u> mos. <u>16</u> ds. If LESS than 1 day, hrs. OR min. ? | | | | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Printer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Retired</u> | | | | | | | | |
| 9 BIRTHPLACE (State or country) <u>St. Mary's Co. Maryland</u> | | | | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Benedict Gates</u> | | | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Charland</u> | | | | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Sarah Thompson</u> | | | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u> | | | | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. H. K. Graham</u> (Address) <u>Chestertown Md</u> | | | | | | | | |
| 15 Filed <u>May 8</u> , 191 <u>4</u> <u>W. J. Nickles</u> REGISTRAR <u>Local</u> | | | | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | | | |
| 16 DATE OF DEATH <u>May 7</u> , 191 <u>4</u> (Month) (Day) (Year) | | | | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Apr. 9th</u> , 191 <u>4</u> , to <u>May 7th</u> , 191 <u>4</u> , that I last saw him alive on <u>May 7th</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>9.20 p.m.</u> The CAUSE OF DEATH* was as follows: <u>Paralysis</u> | | | | | | | | |
| Contributory (Duration) yrs. mos. <u>70</u> ds. Secondary <u>Cerebral hemorrhage</u> | | | | | | | | |
| (Signed) <u>Dr. J. E. Ferguson</u> , M. D. <u>St. Mary's</u> , 191 <u>4</u> . (Address) <u>Chestertown Md</u> | | | | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence | | | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Medley's Neck St. Mary's</u> DATE OF BURIAL <u>May 11</u> , 191 <u>4</u> 20 UNDERTAKER <u>J. E. Ferguson</u> ADDRESS <u>Chestertown Md</u> | | | | | | | | |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1. | | | | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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